EVALUATING PATIENT SAFETY CULTURE AND ITS IMPACT ON CLINICAL OUTCOMES IN THE HOSPITALS IN DELHI NCR

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Title: Evaluating Patient Safety Culture and Its Impact on Clinical Outcomes in the hospitals in Delhi NCR

1. INTRODUCTION

1.1. Patient safety culture

Patient safety culture denotes to the collective values, attitudes, behaviors and perceptions within a healthcare organization that prioritize and promote patient safety. It encompasses the shared beliefs and norms among healthcare staff regarding the prominence of patient safety, along with the organization's commitment to fostering an environment where patient safety is paramount.

A strong patient safety culture is characterized by several key elements:

a) Open Communication: Staff feels comfortable speaking up about safety concerns, sharing information, and reporting errors without fear of reprisal. There is a free flow of communication across all levels of the organization.

b) Teamwork and Collaboration: Healthcare teams work together cohesively, supporting one another and collaborating effectively to ensure patient safety. Interdisciplinary communication and coordination are emphasized to prevent errors and optimize patient outcomes.

c) Leadership Commitment: Organizational leaders demonstrate a visible and unwavering commitment towards patient safety, providing resources, support, and direction for safety initiatives. They actively engage with staff, promote a culture of safety, and prioritize safety in decision-making processes.

d) Continuous Learning and Improvement: There is a culture of continuous learning and improvement, where staffs are encouraged to identify opportunities for enhancing patient safety, participate in safety training and education, and engage in quality improvement initiatives.

e) Transparency and Accountability: There is transparency regarding errors, adverse events, and near misses, and a commitment to learning from these incidents to prevent recurrence. Staffs are believed responsible for their actions, and there are mechanisms in place to address performance issues and promote accountability.

f) Patient-Centeredness: Patient safety culture recognizes the central role of patients and their families in the healthcare process. Patients are actively involved in

decision-making, and their preferences, values, and safety concerns are respected and prioritized.

g) Empowerment and Engagement: Staff are empowered to take ownership of patient safety and are keenly involved in identifying and addressing safety hazards. They are encouraged to contribute their ideas, suggestions, and feedback for improving safety practices.

Overall, patient safety culture is a fundamental aspect of healthcare quality and is essential for ensuring the delivery of safe, effective, and patient-centered care. It requires a commitment from all sort of the organization, from frontline staff to senior leadership, to build an environment where patient safety is upheld as a core value.

1.2. Measures of patient safety culture

Measures of patient safety culture are essential for healthcare organizations to evaluate the effectiveness of their safety practices and recognize areas for perfection. These measures typically involve surveys, assessments, and evaluations aimed at understanding the approaches, beliefs, and behaviours of healthcare staff regarding patient safety. Here's an overview of some common measures:

a) Surveys: Surveys are widely used to measure patient safety culture. These surveys often consist of a series of questions designed to evaluate various features of safety culture, such as communication openness, teamwork, leadership support, and error reporting. The Agency for Healthcare Research and Quality (AHRQ) provides a widely used survey tool called the Hospital Survey on Patient Safety Culture (HSOPSC).

b) Incident Reporting Systems: Incident reporting systems allow healthcare staff to report errors, near misses, and adverse events. Analyzing the data from these reports can provide insights into the frequency and types of errors occurring within an organization, as well as opportunities for system improvements.

c) Safety Culture Assessments: Healthcare organizations may conduct formal assessments of safety culture using validated tools or frameworks. These assessments often involve interviews, focus groups, and observations to gain a deeper understanding of the underlying factors influencing safety culture.

d) Observational Audits: Observational audits involve direct observation of clinical practices and workflows to identify potential safety hazards or deviations from established protocols. These audits can help organizations identify areas where

improvements in safety culture are needed and assess the effectiveness of interventions.

e) Employee Feedback Mechanisms: Establishing channels for employees to provide feedback on safety issues can help organizations gauge the perceptions and concerns of frontline staff. This feedback can inform safety improvement initiatives and foster a culture of open communication.

f) Benchmarking and Comparative Analysis: Comparing safety culture data with national benchmarks or similar healthcare organizations can provide valuable insights into performance relative to peers and identify areas of strength or weakness.

g) Leadership Walkarounds: Leadership walkarounds involve senior leaders engaging directly with frontline staff to discuss patient safety concerns and gather feedback. These interactions demonstrate leadership commitment to safety and provide an opportunity for staff to voice their concerns.

Thus, measures of patient safety culture encompass various methods aimed at assessing and improving safety attitudes, practices, and systems within healthcare organizations. By implementing these measures, organizations can enhance patient safety outcomes and cultivate a culture of continuous improvement.

2. REVIEW OF LITERATURE

Patient safety culture encompasses the attitudes, beliefs, values, and behaviours regarding patient safety within a healthcare organization. It reflects how safety is prioritized, communicated, and practiced by everyone from frontline staff to leadership. A positive patient safety culture promotes open communication, reporting of errors or near misses without fear of retribution, teamwork, and a commitment to continuous improvement. This culture fosters an atmosphere where healthcare employees sense empowered to speak up about safety concerns, collaborate effectively to prevent errors, and learn from errors to prevent future occurrences. Key components of a strong patient safety culture include leadership commitment to safety, staff involvement in decision-making, clear communication channels, effective training, robust systems for reporting and analyzing errors, and a focus on creating a psychologically safe environment. Ultimately, a patient safety culture is vital for enhancing the quality of care, reducing medical errors, improving patient outcomes, and building trust between patients and healthcare providers.

It is widely believed that insecure health practices may result in death and disability. According to estimates, there is a 1 in 300 probability that a patient would suffer injury as a result of a dangerous practice (WHO Report, 2019). Every year in the US, various preventable adverse events, including prescription errors, infections spread, and falls, result in close to 400,000 fatalities (Nahum, 2021). Furthermore, a global health burden and mortality can result from subpar care (Kruk et al., 2021).

The Institute of Medicine's recommendations to help hospitals enhance patient safety (Kohn et al., 1999; Keepnews & Mitchell, 2003. The first step in creating a safety culture inside a company is to evaluate its current safety culture (Hellings et al., 2007). International accrediting organizations mandate patient safety culture assessments, which give healthcare organizations a clear picture of the patient safety issues that need fast care, help them identify the merits and demerits of their safety principles (Smits et al., 2009), assist care-giving units in identifying the patient safety issues they currently have (Deilkas & Hofoss, 2008), and compare their results to those of other hospitals (Blegen et al., 2009). In addition, patient safety culture emphasizes reporting culture, internalizes safety principles, standards, and attitudes, and translates them into healthcare practices and assurance to preserving perfect health setting (Khoshakhlagh et al., 2019). It also highlights managerial issues pertaining to safeguarding patients.

By combining their understanding, skills, and mind-sets to allow them to adjust to changing health conditions, professional nurses play a critical role in maintaining safe and effective healthcare services (Fukada, 2018). As a patient's first point of contact, nurses are in charge of seeing to it that their needs are satisfied. Nurses may foster a culture that places a high priority on patient safety by offering patient-centred care. They can also take on the role of champions for patient safety, urging others to follow suit and fostering a culture of safety inside the company. The authority to make decisions on patient care and safety, as well as to report any dangerous situations or issues, should be granted to nurses. They can serve as excellent role models for other medical professionals by highlighting the significance of patient safety and setting a high standard for others to aspire to.

In the past few years, a vast amount of data regarding the culture of patient safety have been published. A portion of the literature addresses patient safety culture issues that need to be addressed, elements influencing hospital staff members' reporting of incidents, how the working environment shapes safety, and actions that can be taken to increase safety.

Even though patient safety culture has been widely considered in researches, little is identified about the relationship between patient safety culture determinants and outcomes,

particularly in Eastern European countries. (El-Jardali et al., 2010) carried out one of the earliest studies in the area to evaluate the safety and security culture in hospitals where they found the fact that the factor excellence outcomes received a valued high advocates that nurses thought the quality had improved throughout as well as following the certification procedure. Healthcare size, staff engagement, control of quality, data use, administration, involvement, and encouragement were all associated with improved quality results. The subscale measuring Staff Engagement had the most influence in small-scale hospitals, whereas the variable evaluating quality control, as determined by the Quality Control scale, had a significant effect in small to medium- hospitals.

3. NEED OF THE STUDY

Delhi-NCR is pivotal in medical care due to its dense population, diverse healthcare infrastructure, and concentration of leading hospitals and research institutions. It serves as a regional hub for specialized treatments, attracts patients nationally and internationally, and drives advancements in healthcare innovation and technology. Establishing a robust patient safety culture in hospitals across Delhi-NCR is imperative for several reasons:

a) **Enhanced Patient Outcomes:** A culture focused on patient safety ensures that patients receive high-quality care, reducing the likelihood of medical errors, infections, and adverse events. This straight relates with upgraded patient outcomes and satisfaction.

b) **Trust and Reputation:** A hospital known for its commitment to patient safety gains trust and a positive reputation within the community. Patients are more likely to choose hospitals where they feel safe and well-cared for, leading to increased patient volume and loyalty.

c) **Legal and Financial Ramifications:** Medical errors can have severe legal and economic consequences for hospitals. By prioritizing patient safety, hospitals can curtail the threat of litigation and avoid costly penalties associated with malpractice.

d) **Regulatory Compliance:** Monitoring bodies such as the National Accreditation Board for Hospitals & Healthcare Providers (NABH) emphasize the importance of patient safety in their accreditation standards. Hospitals with a strong patient safety culture are better positioned to meet regulatory requirements and maintain accreditation status.

e) **Staff Well-being and Morale**: A culture of safety not only benefits patients but also promotes the well-being and morale of healthcare staff. When healthcare workers feel supported and empowered to speak up about safety concerns, they are more engaged and motivated in their work.

f) **Continuous Improvement:** A culture that values patient safety fosters a mindset of continuous improvement. Through systematic reporting and analysis of adverse events, near misses, and quality indicators, hospitals can identify areas for improvement and implement strategies to prevent future incidents.

g) **Public Health Impact:** In densely populated regions like Delhi-NCR, where healthcare resources may be limited and the population is diverse, ensuring patient safety is crucial for public health. Preventing healthcare-associated infections and medical errors not only benefits individual patients but also helps control the spread of infectious diseases and promotes overall community health.

h) **Ethical Imperative:** Above all, prioritizing patient safety aligns with the ethical responsibilities of healthcare providers to do no harm and uphold the highest standards of care. It reflects a commitment to putting patients' well-being first and treating them with dignity and respect.

Thus, fostering a patient safety culture in hospitals throughout Delhi-NCR is necessary for positive patient outcomes, building trust, complying with regulations, supporting healthcare staff, promoting public health, and upholding ethical standards in healthcare delivery.

4. OBJECTIVES OF THE STUDY

1) To assessing the current patient safety culture determining the existing attitudes, beliefs, and practices regarding patient safety among healthcare providers in hospitals across Delhi-NCR.
2) To compare patient safety culture across different types of hospitals, specialties, and geographical locations within Delhi-NCR to identify best practices and areas for cross-institutional collaboration and learning.
3) To identify areas for improvement pinpointing specific aspects of patient safety culture that requires enhancement or intervention to reduce medical errors and improve patient outcomes.

4) To understand barriers to reporting by investigating the factors that hinder healthcare workers from reporting incidents, near misses, and concerns related to patient safety, aiming to promote a system of transparency and accountability.
5) To evaluate the impact of interventions measuring the efficacy of initiatives implemented to strengthen patient safety culture, such as training programs, communication strategies, and quality improvement initiatives.

5. RESEARCH PROBLEM

1) There is a significant impact of interventions measuring the effectiveness of initiatives implemented to strengthen patient safety culture, such as training programs, communication strategies, and quality improvement initiatives on the patient safety culture and its outcomes.
2) There is a significant influence of organizational factors on the level of patient safety culture and its outcomes in the hospitals in Delhi-NCR.
3) There is a significant difference in practice of safety culture across different types of hospitals, specialties, and geographical locations within Delhi-NCR.

6. RESEARCH DESIGN

6.1. Types of Research: The nature of this research is descriptive and investigative research because the proposed study will analyse the happening behaviour of the hospitals in Delhi-NCR. So there will be no influence of researcher over the events and happening pertaining to the patient safety culture in the hospitals. Also, in the study, causes of certain behavioural aspect will be investigated and the outcomes of the such behaviour will be analysed.

6.2. Population: All the hospitals in Delhi-NCR.

6.3. Sample Area: Selected hospitals in Delhi-NCR which practice the patient safety culture.

6.4. Sample Size: 20-30 hospitals from the sample area.

6.5. Methods of Sampling: Convenient sampling method.

6.6. Collection of Data: Primary and secondary both types of data will be collected for the research work. Primary data will be collected through structured questionnaire or schedules. The respondents will be the ICUs, nursing department, administrative department and communication etc. of the hospital in the sample area. Also, the primary data will be collected through the patients and by

observations made. Secondary data will be gathered through journal, papers, book, magazines, hospital records and Government Reports, etc.

6.7. **Statistical Tools and Techniques:** Statistical tools like N Par test for descriptive analysis, Simple and Multiple Correlation Analysis for testing casual correlation among variables, Regression Analysis for measuring cause effect relation between variables, ANOVA, Chi Square Test for measuring the significant difference, Cronbach's alpha for validation of data may be used in the proposed research work.

7. Significance of the Study

The outcomes of the study and the suggestion may be helpful in fostering a patient safety culture in hospitals throughout Delhi-NCR is important for positive patient outcomes, building trust, complying with regulations, supporting healthcare staff, promoting public health, and upholding ethical standards in healthcare delivery.

8. **Tentative Chapter Planning:** The tentative chapter planning of the research report (thesis) will be as follows:

Chapter Number	Name of the Chapter
Chapter - 1	Introduction
Chapter - 2	Review of Literature
Chapter - 3	Research Methodology
Chapter - 4	Collection of Data and Analysis
Chapter -5	Testing of Hypotheses
Chapter - 6	Conclusion, Recommendations and Suggestions

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